

Summary of Benefits

Traditional Choice® Indemnity Medical Plan

Effective January 1, 2008

Plan Provisions	Traditional Choice Indemnity Benefits
Plan Benefits*	
Calendar Year Deductible	
★ Individual	\$200
★ Family of 2	\$400 (2 times individual)
★ Family of 3 or more	\$600 (3 times individual)
Out-of-Pocket Limit (the maximum amount you pay for your share of covered expenses in a calendar year. Pharmacy copays, expenses covered at 50% and non-covered expenses do not count toward your Out-of-Pocket Limit)	
★ Individual	\$3,000
★ Family of 2	\$6,000 (2 times individual)
★ Family of 3 or more	\$9,000 (3 times individual)
Lifetime Maximum	Unlimited
Hospital Precertification Please see your Summary Plan Description (SPD) for details.	You must precertify any scheduled hospital stay. \$500 penalty for failure to precertify (penalty waived if you are overseas)
Preventive Care	
★ Routine physical exam and immunizations (one per calendar year)	100%, no deductible
★ Well-child care and immunizations Birth to age 7. Please see your SPD for age and frequency schedule.	100%, no deductible
★ Routine gynecological exam including Pap test and related lab fees (one per calendar year)	100%, no deductible
★ Routine Mammogram (one per calendar year for women age 35 and over)	100%, no deductible
★ Prostate screening exam (one per calendar year for men age 40 and over)	100%, no deductible
★ Routine eye exam (one per calendar year)	100%, no deductible
★ Prescription eyewear - lenses, frames and contacts You are also eligible to use Aetna Vision SM Discounts	100% up to a \$150 maximum benefit per person per calendar year
★ Routine hearing exam (one per calendar year) You are also eligible to use the HearPO [®] Hearing Discount Program	100%, no deductible
★ Hearing aids (\$1,000 lifetime maximum) You are also eligible to use the HearPO [®] Hearing Discount Program	100%, no deductible
Physician Services	
★ Office visits for treatment of illness or injury	80% after deductible
★ Diagnostic lab and X-ray	80% after deductible
★ Maternity care office visits	80% after deductible
★ In-office surgery	100% of first \$1,000, no deductible; then 80% after deductible
★ Physician hospital visits	80% after deductible
★ Anesthesia	80% after deductible
★ Allergy testing, serum and injections	80% after deductible
★ Specialists (office visits)	80% after deductible
★ Second surgical opinion	100%, no deductible
Hospital Services	
★ Inpatient hospital room and board and ancillary services	80% after deductible
★ Inpatient and outpatient surgery	80% after deductible
★ Outpatient services	80% after deductible
★ Pre-operative testing	80%, no deductible
★ Other hospital services	80% after deductible
Emergency Care	
★ Hospital emergency room	80% after deductible
★ Hospital emergency room for non-emergency care	50% after deductible
★ Ambulance	80% after deductible

* Coverage is subject to reasonable and customary charges.

Summary of Benefits

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Effective January 1, 2008

continued

Plan Provisions		Traditional Choice Indemnity Benefits	
Plan Benefits*			
Other Health Care			
★ Convalescent facility (up to 90 days per calendar year)	80% after deductible		
★ Home health care (up to 90 visits per calendar year)	80% after deductible		
★ Private duty nursing (up to 70 eight-hour shifts per calendar year)	80% after deductible		
★ Hospice (inpatient and outpatient)	100%, no deductible		
★ Independent lab and X-ray facilities	80% after deductible		
★ Voluntary sterilization	80% after deductible		
★ Short-term rehabilitation (60-day maximum per course of treatment)	80% after deductible		
★ Durable medical equipment	80% after deductible		
★ Spinal disorder (chiropractic) (20 visits per calendar year)	80% after deductible		
★ Bariatric surgery	50% after deductible		
Mental Health Care**			
★ Inpatient	80% after deductible; up to 60 days per calendar year; 60% thereafter		
★ Outpatient (up to 45 visits per calendar year)	80% after deductible		
** Outpatient day maximums for mental health and substance abuse are not combined.			
Substance Abuse Treatment***			
★ Inpatient (up to 45 days per calendar year)	80% after deductible		
★ Outpatient (up to 45 visits per calendar year)	80% after deductible		
** Outpatient day maximums for mental health and substance abuse are not combined.			
Prescription Drug Benefits			
<i>Participating Retail Pharmacy Program</i> (up to a 30-day supply purchased at a local participating pharmacy)		<i>Participating Pharmacies</i>	<i>Non-Participating Pharmacies</i>
★ Generic drugs		100% after \$10 copay	Not covered
★ Formulary brand-name drugs		100% after \$25 copay	Not covered
★ Non-formulary brand-name drugs		100% after \$35 copay	Not covered
<i>Prescriptions Purchased Overseas</i>			
★ Generic drugs		Not applicable	100% after deductible
★ Brand-name drugs		Not applicable	80% after deductible
<i>Mail-Order Service</i> (up to a 90-day supply)			
★ Generic drugs		100% after \$20 copay	
★ Formulary brand-name drugs		100% after \$40 copay	
★ Non-formulary brand-name drugs		100% after \$60 copay	

* Coverage is subject to reasonable and customary charges.



This chart displays only a general description of your benefits under the DoD NAF HBP. Should there be a conflict between the benefits shown on the chart and those in the Summary Plan Description (SPD), the terms of the SPD will be used to determine coverages and benefits.